CS-1766
REV 5/2003

State of Michigan
Department of Civil Service
Employee Benefits Division
400 South Pine Street, P.O. Box 30002, Lansing, MI 48909

NOTIFICATION BY EMPLOYEE/RETIREE OF QUALIFYING EVENT

INSTRUCTIONS: This form is used to notify the State of Michigan of a qualifying event and the name(s) and address(es) of family members who will be removed from insurance coverage. Make and retain a copy for your records. Employees should return the completed form to their Human Resources Office. Retirees should return the completed form to State Employees Retirement System, P.O. Box 30171, Lansing, MI 48909. If this form is returned in a timely manner, the information will be used to notify the family members of their rights to continue insurance coverages. Please complete the top portion of this form and either Section I if you are recently divorced, or Section II if you have a dependent child no longer eligible. A portion of this information is protected by federal privacy laws and/or state confidentiality requirements.

PRINT OR TYPE

NAME OF EMPLOYEE/RETIREE (Last, First, MI)	**SOCIAL SECURITY NO OF EMPLOYEE/RETIREE**
ADDRESS OF EMPLOYEE/RETIREE (City, State, Zip)	**EMPLOYEE ID NUMBER**

I hereby notify the State of Michigan that the following event has occurred:
☐ **Divorce –** ***Complete Section I*** ☐ **Dependent Child No Longer Eligible –** ***Complete Section II***

I hereby authorize the State of Michigan to disclose my health information related to current state health plan enrollments to the spouse and dependents listed below during the next 90 days to enable them to pursue continued coverage as required by federal law. I recognize that the spouse and dependents may redisclose this information. I understand that I may inspect this information and that I may revoke this authorization in writing with the office to which this form was submitted.

SIGNATURE OF EMPLOYEE/RETIREE	**DATE (MM/DD/YYYY)**

SECTION I - DIVORCE

NAME OF SPOUSE	**SOCIAL SECURITY NUMBER**
ADDRESS	**DATE OF DIVORCE (MM/DD/YYYY)**

CITY	**STATE**	**ZIP CODE**	**WORK PHONE**	**HOME PHONE**

Name(s) of Dependent Child(ren) being removed from coverage

LAST	**FIRST**	**DATE OF BIRTH (MM/DD/YYYY)**	**SOCIAL SECURITY NUMBER**

SECTION II – DEPENDENT CHILD NO LONGER ELIGIBLE

NAME OF CHILD	**SOCIAL SECURITY NUMBER**
ADDRESS	**DATE OF INELIGIBILITY (MM/DD/YYYY)**

CITY	**STATE**	**ZIP CODE**	**WORK PHONE**	**HOME PHONE**

IMPORTANT NOTE: THIS FORM MUST BE RETURNED WITHIN 60 DAYS OF THE DATE OF THE EVENT